Paramount Care, Inc.: LUCAS COUNTY EMPLOYEES

Coverage Period: 3/1/2016 - 2/28/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Single/Family | **Plan Type:** HMO

This is only a summary*: A quick reference guide to coverage and costs under the Plan. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.paramounthealthcare.com** or by calling **1-800-462-3589**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Single **$0** (Paramount Ohio HMO Network.) Family **$0** (Paramount Ohio HMO Network.) Does not apply to preventive care or covered services requiring a copayment.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, March 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. **Does not currently apply to Lucas County employees.**
Are there other deductibles for specific services?	Yes. **$500** for services provided by Centers of Excellence.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	**$1500** Single (Paramount Ohio HMO Network.) **$3000** Family (Paramount Ohio HMO Network.)	The out-of-pocket limit is the most co-insurance you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, copayments and coinsurance for Supplemental Health Services such as home health care, durable medical equipment, prosthetic devices, chiropractic care, outpatient physical/occupational/speech therapy, infertility services, vision care services, vision rebate, prescription drugs and any penalties. Deductibles for Centers of Excellence will accumulate toward satisfying the annual out-of-pocket maximum.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.paramounthealthcare.com/FindAProvider for a list of Paramount Ohio HMO Network Providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

- **Co-Payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 25% would be $250. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **co-payments**, and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use A(n) Paramount Ohio HMO Network. Provider	Your Cost If You Use A(n) Out-of-Network Provider	Limitations & Exclusions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 Co-pay/visit.	Not covered.	————————none————————
	Specialist visit	$15 Co-pay/visit.	Not covered.	————————none————————
	Other practitioner office visit	$20 for Chiropractic Services.	Not covered.	Chiropractic limited $20 Copay per visit up to $500 contract year maximum per Member.
	Preventive/care/screening/immunization	Covered in full.	Not covered.	————————none————————
If you have a test	Diagnostic test (x-ray, blood work)	25% Co-Insurance.	Not covered.	————————none————————
	Imaging (CT/PET scans, MRIs)	25% Co-Insurance.	Not covered.	Prior authorization may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.co.lucas.oh.us/index.aspx?nid=237	Prescription Drug Coverage	Lucas County coverage through TotalScript	Lucas County coverage through TotalScript	See Prescription Drug coverage at www.co.lucas.oh.us/index.aspx?nid=237
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% Co-Insurance.	Not covered.	Prior authorization may be required.
	Physician/surgeon fees	25% Co-Insurance.	Not covered.	————————none————————
If you need immediate medical attention	Emergency room services	$100 Co-pay/visit.	Payable under HMO network of benefits.	Waived if admitted.
	Emergency medical transportation	25% Co-Insurance.	Payable under HMO network of benefits.	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use A(n) Paramount Ohio HMO Network. Provider	Your Cost If You Use A(n) Out-of-Network Provider	Limitations & Exclusions
If you need immediate medical attention	Urgent care	$15 Co-pay/visit.	Payable under HMO network of benefits.	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	25% Co-Insurance.	Not covered.	Prior authorization required.
	Physician/surgeon fee	25% Co-Insurance.	Not covered.	————————none————————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Covered Services subject to the same deductible, copayments and/or coinsurance as any other physical disease or condition.	Not covered.	————————none————————
	Mental/Behavioral health inpatient services	Covered Services subject to the same deductible, copayments and/or coinsurance as any other physical disease or condition.	Not covered.	————————none————————
	Substance abuse disorder outpatient services	Covered Services subject to the same deductible, copayments and/or coinsurance as any other physical disease or condition.	Not covered.	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use A(n) Paramount Ohio HMO Network. Provider	Your Cost If You Use A(n) Out-of-Network Provider	Limitations & Exclusions
If you have mental health, behavioral health, or substance abuse needs	Substance abuse disorder inpatient services	Covered Services subject to the same deductible, copayments and/or coinsurance as any other physical disease or condition.	Not covered.	————————none————————
If you are pregnant	Prenatal and postnatal care	Covered in full.	Not covered.	————————none————————
	Delivery and all inpatient services	25% Co-Insurance.	Not covered.	————————none————————
If you need help recovering or have other special health needs	Home health care	25% Co-Insurance.	Not covered.	————————none————————
	Rehabilitation services	25% Co-Insurance.	Not covered.	Inpatient Rehabilitation is covered up to 60 days per contract year. Outpatient physical, occupational and speech therapy $25 Co-payment up to 30 visits combined.
	Habilitation services	25% Co-Insurance.	Not covered.	Inpatient Habilitation is covered up to 60 days per contract year. Outpatient physical, occupational and speech therapy $25 Co-payment up to 30 visits combined.
	Skilled nursing care	25% Co-Insurance.	Not covered.	Limited to 100 days per contract year.
	Durable medical equipment	25% Co-Insurance.	Not covered.	Subject to Medicare Part B Guidelines.
	Hospice service	25% Co-Insurance.	Not covered.	————————none————————
If your child needs dental or eye care	Eye exam	Covered in full.	Not covered.	One routine vision exam every twelve (12) months.
	Glasses	$100 Rebate	Same as In-network.	Vision Hardware: Rebate every 24 months toward the purchase of vision hardware with itemized receipt from any vision or optical provider.
	Dental check-up	Covered on Dental Plan	Covered on Dental Plan	————————none————————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• **Acupuncture** • **Dental care (Adult)** • **Long-term care** • **Private-duty nursing**	• **Bariatric Surgery** • **Hearing Aids** • **Non-emergency care when traveling outside the U.S.** • **Routine foot care**	• **Cosmetic surgery** • **Infertility treatment** (Unless Mandated) • **Prescription Drugs** • **Weight loss programs**

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• **Allergy Treatment**	• **Chiropractic care**	• **Routine eye care (Adult)**

Your Rights to Continue Coverage

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact Lucas County at 419-213-4211. You may also contact your state insurance department at (614) 644-2673, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Paramount Care, Inc. Member Service Department at (419) 887-2525 or Toll Free at 1(800) 462-3589, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, you can contact the Ohio Department of Insurance at (614) 644-2673, or Toll Free at (800) 686-1526.

About these Coverage Examples:

These examples show how a plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Do not use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)	
• **Amount owed to providers:**	$7,540
• **Plan pays:**	$6,060
• **Patient pays:**	$1,480
Sample care costs:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**
Patient Pays:	
Deductibles	$0
Co-pays	$20
Co-insurance	$1,290
Limits or exclusions	$170
Total	**$1,480**

Managing type 2 diabetes (routine maintenance of a well-controlled condition)	
• **Amount owed to providers:**	$5,400
• **Plan pays:**	$2,020
• **Patient pays:**	$3,380
Sample care costs:	
Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory Tests	$100
Vaccines, other preventive	$100
Total	**$5,400**
Patient Pays:	
Deductibles	$0
Co-pays	$100
Co-insurance	$350
Limits or exclusions	$2,930
Total	**$3,380**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**
- Sample care costs are based on national averages supplied by the US Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition would be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare Plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Lucas County Prescription Drug Plan
Summary of Benefits and Coverage

*A quick reference guide to coverage and costs under the Plan

Administered by: Navitus Health Solutions, 2601 West Beltline Highway, Suite 600, Madison, WI 53713 1-866-333-2757

The benefit plan year for all benefits begins March 1, 2016 and continues through February 28, 2017

Benefit level for Non-Drug Use Review Participants and Mail Order:

- TIER I: 20% co-pay for generic medication, with a minimum $5 per script and a maximum of $20 per script up to a 30-day supply retail & 90-day supply mail order.
- TIER II: 20% co-pay with a minimum $40 per script and a maximum $100 per script for brand name medication up to a 30-day supply retail & 90-day supply mail order.
- TIER III: 20% or $40.00 (whichever is greater) co-pay with no cap up to a 30-day supply retail & 30-day supply mail order

Benefit level for Drug Use Review Participants:

- TIER I: 20% co-pay for generic medication up to $8 per script for up to a 90-day supply.
- TIER II: $25 per script for brand name medication up to a 90-day supply.
- TIER III: 20% or $40.00 (whichever is greater) co-pay up to a 30-day supply.

- Enrollees who complete the program will have their annual out-of-pocket maximum for Tier II brand name medications limited to $350.00/year and a $500.00/year out-of-pocket maximum for Tier III medications.
- Enrollees will also be eligible to receive up to $50.00 worth of coupons toward their Tier II prescription drug co-pyaments at the participating pharmacy.
- **Medications may be subject to change among Tiers during the course of the plan year.**
- **All medications costing in excess of $500 must be referred to the claims administrator for prior authorization. Any specialty medication costing in excess of $1,000 per script will be subject to medical management review and may be redirected for dispensing only through a specifically selected specialty pharmacy.**
- **Employees and/or family members on certain medications will be required to comply with a mandatory step formulary component .**
- **All brand name proton pump inhibitors, including Nexium, are not covered.**
- **The Plan will continue to pay 100% of the cost of certain over the counter (OTC) medications for enrollees with a prescription. These include, but may not necessarily be limited to: Prilosec OTC 20 mg, Prevacid 24 hr., Claritin Syrup, Claritin Tablets, Claritin Reditab, Claritin-D 24 and store brand laratadine D-24 tablets. You must have a valid written prescription from your physician in order to receive this benefit.**
- **NEW: Effective March 1, 2013, consistent with the provisions of the Affordable Care Act Rules on expanding access to preventive services for women, the plan will provide access to certain FDA approved generic contraceptive medications without the requirement of a co-payment or co-insurance (excludes abortifacient drugs).**

If you use a non-participating pharmacy, eligible expenses will be reimbursed at a reduced level. If you are vacationing or traveling outside of the network, you must purchase the prescription and submit eligible expenses for reimbursement, minus the applicable deductible. You may obtain reimbursement claim forms on the Lucas County Employee Benefits website, or in the Employee Benefits Department, Suite 440, in the Government Center.

Injectible insulin and oral contraceptives are covered. Disposable syringes and needles are also covered, but only when prescribed with insulin. Insulin and Human Organ Transplant drugs shall be considered generic for purposes of the Lucas County Drug Plan and are subject to the generic co-pay.

Generic Drug Policy: If a Brand Drug is dispensed when a generic equivalent is available, then the Member is responsible for the copay plus any cost differential between the Brand name and the Generic.

Coordination of Benefits Policy: If any eligible person is entitled to prescription drug benefits under another plan, and the eligible person is primary on that plan, expenses will be coordinated so that the primary plan pays first and the secondary plan pays the remaining eligible expense to the applicable co-payment amount. Dependent children fall under the "Birthday Rule" which states that whichever parent's birthday comes first in the calendar year, that parent's coverage will be primary, unless a specific court order states otherwise. In order to receive the secondary refund to the applicable co-payment amount, a claim form must be completed and submitted to Navitus at the address above.

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